Supreme Court, U.S.
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No. 98-1836

IN THE

Supreme Court of the United States

UNITED STATES HEALTHCARE SYSTEMS OF PENNSYLVANIA, INC.,

Petitioner,

v.

PENNSYLVANIA HOSPITAL INSURANCE CO. AND THE COMMONWEALTH OF PENNSYLVANIA MEDICAL PROFESSIONAL LIABILITY CATASTROPHE LOSS FUND,

Respondents.

ON PETITION FOR A WRIT OF CERTIORARI TO THE PENNSYLVANIA SUPREME COURT

SUPPLEMENTAL BRIEF FOR RESPONDENTS IN RESPONSE TO BRIEF FOR THE UNITED STATES AS *AMICUS CURIAE* AND SUPPLEMENTAL BRIEF OF PETITIONER

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29 U.S.C. § 1132(a) 7

The *amicus curiae* brief submitted by the United States and the supplemental brief submitted by petitioner in response to that brief should not persuade your Honorable Court to grant the petition for writ of certiorari in this case. Instead, your Court should deny the petition, or revisit it through new briefs from the parties and the government after the Court has rendered its decision in *Pegram v. Hendrich*, No. 98-1949 (to be argued 2/23/00).

Even a casual reading of *Metropolitan Life Ins. Co. v. Massachusetts*, 471 U.S. 724 (1985), *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41 (1987), *New York State Conference of Blue Cross & Blue Shield Plans v. Travelers Ins. Co.*, 514 U.S. 645 (1995), and *DeBuono v. NYSA-ILA Medical and Clinical Services Fund*, 520 U.S. 806 (1997) instantly reveals that the Pennsylvania Supreme Court correctly perceived a fundamental change in the analytical course that your Court charted to determine the validity of a claim to preemption under ERISA.

The *Metropolitan Life/Pilot Life* approach emphasized the general nature of the preemption clause's "relates to" phrase and the structure of the preemption and exception clauses: if the matter has some impact on an ERISA plan, then it may be preempted, unless it falls within the scope of the insurance exception to preemption. Thus, under the approach delineated in *Metropolitan Life/Pilot Life*, conduct that does or might affect an ERISA plan is presumptively preempted unless it falls within the scope of the exceptions to ERISA's broad preemption provision. *Metropolitan Life, supra*, 471 U.S. at 739; *Pilot Life, supra*, 481 U.S. at 47-48.

In contrast, the approach delineated in *Travelers* and *DeBuono*, began with the recognition that emphasis on the "relate to" phrase can produce a sweep of federal preemption far beyond the scope intended by Congress when it enacted ERISA, because virtually everything can be connected to an ERISA plan. *Travelers, supra*, 514 U.S. at 655; *DeBuono, supra*, 520 U.S. at 813. The *Travelers/DeBuono* analysis also recognizes that the operative and beginning presumption is against preemption, and it places on the party claiming

preemption "the considerable burden of overcoming 'the starting presumption that Congress does not intend to supplant state law'," *DeBuono*, 520 U.S. at 814, quoting *Travelers*, 514 U.S. at 654. Under the approach implemented in *Travelers* and followed in *DeBuono*, since preemption claims turn on Congress's intent, "we begin as we do in any exercise of statutory construction with the text of the provision in question, and move on, as need be, to the structure and purpose of the Act in which it occurs," *Travelers*, 514 U.S. at 655.

Your Honorable Court, of course, had no occasion to overrule *Metropolitan Life* and *Pilot Life* when it decided *Travelers* and *De Buono*. *Metropolitan Life* presented state action that squarely affected the substantive provisions of an ERISA plan. *Pilot Life* presented a state action that squarely conflicted with ERISA's contractual enforcement provisions. Because the state actions in those cases clearly "related to" ERISA plans and plainly conflicted with federal provisions, the Court had no reason to consider the implications of the "insofar as" limitation that Congress engrafted onto the "related to" preemption clause. *See DeBuono, supra*, 520 U.S. at 813.

This case presents a tort claim against an HMO.[1] The claim, which has not fully developed its record and on whose ultimate merits the Pennsylvania Supreme Court expressly withheld judgment, posits that the HMO contributed to the injury sustained by Mr. Pappas by referring Mr. Pappas to be treated at one of the HMO's participating hospitals without determining that those hospitals were prepared to treat him with the dispatch that his emergent medical condition demanded, at a time when another facility, not associated with the HMO, was capable of providing appropriate and timely care.[2] In essence, the case

1. In *Mackey v. Lanier Collections Agency and Service*, 486 U.S. 825, 833 (1988), your Honorable Court suggested that commonplace tort claims were not displaced by ERISA. (Respondents do not suggest that petitioner is an ERISA plan).

2. Although the record facts are "limited", Brief for the United States as Amicus Curiae ("U.S. brief"), p. 7, they suggest that the (Cont'd)

involves a treatment decision by the HMO to be adjudged on the basis of the standards applicable to all medical care providers in Pennsylvania, not just HMOs.

Of course, in order to draw this case under the penumbra of *Pilot Life*, the government's brief and the petitioner's filings put the proverbial rabbit into the hat by equating the conduct of the HMO in this case with the conduct of an ERISA plan administrator in making a benefits determination.

Contrary to the narrow view espoused by petitioner and endorsed by the government, the case does not simply involve a challenge to a benefits determination. Indeed, as the government's brief correctly observes, with no contradiction from petitioner, there is no question that the HMO's provisions entitled Mr. Pappas to be treated at any hospital, not just at the hospitals preferred by the HMO. Additionally, the standard by which the conduct of the HMO is ultimately and yet to be adjudged is not based on the terms of the employer's benefit plan nor on the provisions of the HMO's documents, provisions that are not restricted to any particular ERISA plan, but on the standard of care to be followed by all health care providers in the Commonwealth of Pennsylvania. Furthermore, the remedy sought in this case is not the payment of an allegedly

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(Cont'd)
ultimate decision by the HMO was a medical determination, either that Mr. Pappas' condition was not a true emergency or that there was no need to have him treated at a hospital that was not affiliated with the HMO. Dr. Dickter, the Haverford emergency room physician who personally attempted to persuade the HMO to change its veto against transporting Mr. Pappas to a non-affiliated hospital that he had ascertained was ready to accept and treat Mr. Pappas, testified that he emphasized to the HMO representatives that the situation confronting Mr. Pappas was a neurological emergency, and that his pleas for the HMO to reevaluate and change its decision were reviewed and disapproved by the HMO's Dr. Liebowitz. *See* Pennsylvania Supreme Court Reproduced Record, p. 70a-72a, 77a (deposition testimony of Dr. Dickter), and p. 93a (typewritten transcript of emergency room chart).

contractually owed payment, but damages for personal injury in the form of contribution by an alleged joint tortfeasor.

Moreover, the equation that petitioner and the government assume between the HMO in this case and an ERISA plan or an ERISA plan administrator, in order to squeeze this case under the holding of *Pilot Life*, does not withstand close scrutiny. In *Pilot Life*, as recognized by the government's brief, the insurance company was the administrator of the ERISA plan. Similarly, in *Travelers*, the plaintiffs were commercial insurers, acting as fiduciaries of ERISA plans they administered. 514 U.S. at 651. In *DeBuono*, respondents were trustees of a fund which administered a benefit plan. 520 U.S. at 810.

Here, however, the target of the action is not the ERISA plan nor the administrator of the plan. As the government's brief concedes, without contest by petitioner's responsive supplemental brief, the petitioner's HMO "is not an ERISA plan; rather it is a service provider to the plan and to its participants and beneficiaries," (U.S. brief, p. 10; *see also*, U.S. brief, p. 9, asserting that the "Pennsylvania appellate courts incorrectly assumed that petitioner's HMO is identical to the employee benefit plan sponsored by Mrs. Pappas's employer.").

As a service provider, the HMO is neither the plan nor the plan administrator. The HMO's invocation of ERISA to shield itself from tort liability in this case, when there is no basis in the record to regard it as the employer's benefits plan or as the administrator of the employer's plan, is highly questionable. As your Honorable Court reiterated in *Travelers*, 514 U.S. at 656-657,

> in passing 514(a), Congress intended "to ensure that plans and plan sponsors would be subject to a uniform body of benefits law; the goal was to minimize the administrative and financial burden of complying with conflicting directives among States or between States and the Federal Government . . . , [and to prevent] the potential for conflict in substantive law . . . requiring the tailoring of plans

> and employer conduct to the peculiarities of the law of each jurisdiction."

The tort action presented in this case, however, does not affect the plan or the plan administrator, nor does it involve a conflict with the federal government's directives regarding employee benefit plans.[3]

The question thus is whether your Honorable Court need intervene, in this particular case and at an early stage of its development, to decide whether a common law malpractice claim against a health care service provider is preempted by ERISA. Respondents contend the answer should be "no," because your Court's precedents demonstrate that Congress had no intent to remove such claims from their traditional roles in the states' interests, and because this case has not yet developed to the stage where your Honorable Court can exercise its limited jurisdiction over final state court decisions and provide definitive guidance to all lower courts.

As to whether the tort claim asserted against the HMO in this case has a "connection with" the ERISA plan, "[w]e simply must go beyond the unhelpful text and the frustrating difficulty of defining its key term, and look instead to the objectives of the ERISA statute as a guide to the scope of the state law that Congress understood would survive," *Travelers*, 514 U.S. at 656.

Given the goal of ERISA to protect employee benefit plans and their administrators from the problems inherent in dealing with various state substantive and enforcement mandates for employee health care benefits, and given the government's

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3. Notably absent from the government's brief and from the petitioner's filings is any specific prohibition either in ERISA or in the Department of Labor's implementing regulations against health care malpractice claims asserted against health care providers. Indeed, the government's brief concedes, without the slightest challenge from petitioner, that "When an HMO acts as a medical service provider, a number of courts have held — and we agree — that the HMO is subject to suit under state law for negligence in performing its medical duties" (U.S. brief, p. 10).

concession that HMO's can be sued under state law for their negligence as health care providers, one easily draws the conclusion from your Court's pronouncements in *Travelers* and in *DeBuono* that Congress did not intend to displace state malpractice law simply because the service provided can be linked to an ERISA plan. To paraphrase what the Court stated in *DeBuono*, 520 U.S. at 815, this is not a case in which the existence of a pension plan is a critical element of a state law cause of action, or one in which the state law contains provisions that expressly refer to ERISA or ERISA plans. A consideration of the actual operation of the state law leads to the conclusion that the malpractice claim asserted against petitioner's HMO is one of "myriad state laws" of general applicability that may impose some burdens on ERISA plans but nevertheless do not "relate to" them within the meaning of ERISA.

In *Travelers*, 514 U.S. at 661, your Court pointed out that the ERISA preemption clause cannot be read "to displace general health care regulation, which historically has been a matter of local concern". When Congress enacted ERISA, all of the states had traditionally allowed, and regulated to varying extents, health care malpractice claims. "And yet there is not so much as a hint in ERISA's legislative history or anywhere else that Congress intended to squelch these state efforts," *Travelers*, 514 U.S. at 665.[4]

Further consideration of the arguments advanced by the government and by the petitioners that Congress may have sought to displace state malpractice claims elicits an additional

4. The recent congressional activities regarding patient's rights alluded to in footnote 5 at pages 7-8 of the government's brief, do not necessarily indicate a sentiment that ERISA was meant to displace the type of claim at issue in this case. Those activities can also and perhaps more properly be viewed as seeking clarification of the limited preemption effected by ERISA and a correction of the lower court decisions that, unlike the decision of the Pennsylvania Supreme Court, have misinterpreted both the intent of Congress and the pronouncements of your Honorable Court.

distinction between this case and *Pilot Life* that the government's brief and the petitioner's filings fail to appreciate. When Congress entered the field of employee benefit plan regulation through the enactment of ERISA, the legislative choice was between diversity and uniformity, not between a contractual cause of action and concomitant relief and no cause of action or relief whatsoever. Congress gave ERISA participants and beneficiaries some cause of action and some relief akin to the cause of action and the relief asserted by the claimant in *Pilot Life*. Because the *Pilot Life* plaintiff retained the federal cause of action and remedies provided by ERISA with respect to the insurer's denial of benefits, the task of your Honorable Court in that case was to determine whether that cause of action and its remedies could be enlarged by the state cause of action and remedy.

However, in the context of a health care malpractice action against a service provider, such as this case, the Court's considerations are very different. The petitioner and the government urge the Court to rule that Congress usurped a traditional state field of law *without providing a parallel federal field of law* as it did with respect to the essentially contractual terms of ERISA.[5] Without a stronger indication of congressional intent beyond what petitioner and the government divine from the absence of a malpractice cause of action in ERISA, your Honorable Court should not assume that Congress intended to eradicate state health care malpractice actions against service providers such as the HMO in this case.

For these reasons, and those delineated in its Brief in Opposition, respondents respectfully suggest that your Honorable Court deny the petition for allowance of appeal, because the decision of the Pennsylvania Supreme Court is in accord with ERISA and with the controlling decisions of your Honorable Court.

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5. That the congressional usurpation was limited to essentially contractual matters is evident in the remedial provisions of ERISA's section 502(a), as set forth in 29 U.S.C. § 1132(a).

The fears expressed by petitioner and by the government regarding the effect of a denial of the petition in this case are unfounded. The denial of a petition for a writ of certiorari does not represent a decision by your Court on the merits of the case or even on the merits of the issues for which review was sought. *Maryland v. Baltimore Radio Show, Inc.*, 338 U.S. 912, 917 (1950). Thus, a denial of the petition at this stage of the case's development would not stamp the imprimatur of your Honorable Court onto the decision of the Pennsylvania Supreme Court, nor would it compel other jurisdictions to follow the decision of that court.[6]

The denial of the petition at this stage of the case's development is particularly appropriate in light of the sketchy nature of the case and the real possibility that the petitioner will ultimately not be found liable. The decision of the Pennsylvania Supreme Court adjudged only the viability of the claim presented in the joinder complaint. That complaint presents only the barest of facts, and remains subject to amendment for the presentation of additional facts and further refined legal theories. Moreover, the Pennsylvania Supreme Court expressly refused to adjudge the merits of the claim as presented by the pleadings, and specifically noted that the petitioner might ultimately persuade the factfinder of its defenses or might be entitled to exoneration as the development of the case progressed (Petition, p. 13a, n.7).

In the alternative, but for different reasons, respondents join with the government in asking that your Honorable Court defer action on the petition until after it renders its decision in *Pegram*, and adds the request that the parties and the government be

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6. As of January 27, 2000, Shepard's reported only one state appellate court case citing the decision of the Pennsylvania Supreme Court. In that case, *Hinterlong v. Baldwin*, 720 N.E.2d 315 (1999), the Appellate Court of Illinois, Second District, first made its own determination of the controlling principles and the issue, 720 N.E.2d at 320-321, before it mentioned the Pennsylvania Supreme Court's decision in a string citation, 720 N.E.2d at 322.

allowed to submit further briefs addressing *Pegram's* impact on this case.

Most evident in the government's brief in this case and in *Pegram* is the approach taken by the government to emphasize the action of the HMO, rather than to emphasize the status of the HMO and its relationship to the plan and to its administration. While the government's interest in securing federal authority over and national uniformity for the administration of employee health benefit plans under ERISA is unassailable, the government's approach is open to question. A comparison of the government's petition brief in this case with the merits brief that it filed in *Pegram* underscores the problem that the Court's decision in *Pegram* might resolve. In both cases, the government highlights the distinct existence of the ERISA plan and its administration from the HMOs. Despite the conclusion that ERISA does not or should not apply to an HMO that is neither the plan nor the administrator of the plan, the government's arguments proceed to characterize the nature of the HMOs' conduct. That point of analysis ultimately gets the government to where it wants to be in both cases, but it is one that appears to be inconsistent and largely unworkable.

In the instant case, the government's characterization of the HMO's action as simply a benefits determination allows the government to assert that the case is controlled by *Pilot Life* and that the HMO is subject to ERISA. In *Pegram*, on the other hand, the government stresses the independence of the HMO and its role as a medical provider to reach the conclusion that the HMO is not subject to ERISA. In the instant case, the government acknowledges that the decision made by the HMO may have had a medical treatment basis, but it concludes that the HMO's conduct should be regarded simply as a benefits determination. In *Pegram*, however, the government downplays the obvious benefits determinations made by the HMO doctors and concludes that those decisions cannot possibly be regarded as anything other than medical or purely business decisions.[7]

7. "The HMO and its parent entities are thus service providers to (Cont'd)

Consequently, *Pegram* provides an important platform for the Court to address the government's analysis in each case. The Court's decision in *Pegram* should provide additional clarity for further consideration in the context of this case. If the petition in this case is not denied, it makes sense to defer action on the petition until after the Court has rendered its decision in *Pegram* and to allow further briefing in light of the decision to be made in *Pegram*. On the one hand, the Court's acceptance or rejection of the government's analytical approach will inform the parties and the government of the correct approach to be taken. On the other hand, a delay of *Pegram*, as suggested by petitioner, for the briefing, argument, and decision in this case would unwarrantedly delay the normal operations of the Court, and unnecessarily postpone the guidance of the Court in cases similar to both the instant case and to *Pegram*.

CONCLUSION

For the foregoing reasons and those advanced in its prior briefs, respondents respectfully ask that your Honorable Court deny the petition for writ of certiorari. In the alternative, respondents respectfully ask that the Court defer action on the petition until after it renders its decision in *Pegram*, and that the parties and the government be allowed to submit further briefs addressing *Pegram's* impact on this case.

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the plan; they are not themselves ERISA plans." Brief for the United States as Amicus Curiae, *Pegram v. Herdrich*, 1999 U.S. Briefs 1949, *10 (November 19, 1999). "[A]n HMO, in its role as provider of medical treatment to patients who are beneficiaries of ERISA plans, is not an ERISA fiduciary." *Id.* at *12. "The courts of appeals, however, have correctly held that state laws governing the practice of medicine by HMOs are not preempted by ERISA." *Id.* at *13.

Respectfully submitted,

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